8/15/18
POC accepted
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070033	A. BUILDING _____ B. WING _____	C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBURY HOSPITAL	24 HOSPITAL AVE DANBURY, CT 06810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An authorized substantial allegation survey concluded on July 12, 2018 in response to Complaint #23489. The following Condition of Participation was reviewed at Danbury Hospital: CFR 482.23 Nursing Services	A 000	A 385 **Responsible Leader:** Director of Patient Care Services who oversees Inpatient Services (Medical, Surgical, Critical Care and Behavioral units) will be ultimately responsible for the corrective action and for overall and ongoing compliance. **Plan/System Improvement:**	
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: The Condition of Participation for Nursing Services has not been met based on medical record review, review of telemetry monitoring strips, review of facility policies and interviews for 1 of 10 patients (Patient #1) who had a change in condition and/or changes in telemetry monitoring tracings. The hospital failed to ensure that the RN assessed the patient and/or notified the physician of changes in behavior and/or questionable cardiac rhythm changes. Please refer to A 395	A 385	The hospital will ensure that patients are assessed by a registered nurse. Any changes in behavior and/or questionable cardiac rhythm changes will be reported to the appropriate covering licensed independent practitioner. The Director of Patient Care Services and appropriate stakeholders will review and revise, if indicated, the following policies: • Telemetry Standards of Care • Telemetry Responsibilities of the RN • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns **Implementation:** Clinical nursing staff on the inpatient medical, surgical and critical care clinical units who are responsible for assessments/reassessments and notification of changes in patient condition will review the following policies:	August 10, 2018 Aug 17, 2018
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record reviews, review of facility documentation, review of facility policies	A 395	• Cardiac Monitoring Policy / Danbury Hospital • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lorraine Rotko, Admin Dir Quality Safety & Satisfaction | 8-10-18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 395	Continued From page 1 and interviews for one of ten patients who had a change in condition (Patient #1), the facility failed to ensure the RN responded to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel resulting in a delay in assessment and physician notification. The finding includes: Patient #1 was admitted to the hospital on 4/2/18 with sepsis due to cellulitis with gangrene of the left lower extremity and had a past medical history that included cerebral vascular accident (CVA), diabetes and hypertension. Review of the clinical record dated 4/6/18 noted that the patient had a change in condition and a head CT scan identified that the Patient had a small acute infarct (stroke) involving the left occipital lobe. Patient #1 was transferred to 10W (stroke unit) on 4/6/18 at 4:53 PM. Review of RN#1's assessment dated 4/6/18 at 12:42 AM identified that the patient was calm, appropriate, drowsy, was unable to determine orientation, had normal heart sounds, a regular heart rhythm, unlabored respirations, no shortness of breath, diminished breath sounds (anterior and posterior), and was on three (3) liters of oxygen. The record dated 4/7/18 identified that PCT (patient care tech) #1 documented that the Patient was transferred to the chair with two staff at 3:10 AM. Review of facility documentation identified that the Patient's heart monitor leads were off on 4/7/18 at 1:22 AM, 1:48 AM, 2:30 AM and 2:53 AM, 3:26 AM and 3:27 AM. The Patient's telemetry box was changed at 2:55 AM.	A 395	**A 385 continued** **Monitoring:** A monthly audit of 50* reports of change in cardiac rhythm from the telemetry monitor technician to assigned registered nurse will be conducted for adherence to the following policies: • Cardiac Monitoring Policy / Danbury Hospital • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy This audit will be conducted until 90% compliance is achieved for four consecutive months beginning September 1, 2018. Should the audit reflect a score lower than 90%, re-education will occur with involved clinical staff. The results of this audit will be reported to the Danbury Hospital Quality Improvement Committee until compliance is achieved. The Danbury Hospital Quality Improvement Committee reports to the Quality Improvement Committee of the Board – who is ultimately responsible for the oversight of quality assurance and performance improvement activities for Western Connecticut Health Network. *a 100% audit will be completed should less than 50 reports occur within that month (approximately 140 calls/month occur from telemetry monitor technician to the assigned registered nurse – an audit of 50 cases or 100% is over a 30% review)	Beginning Sept 1, 2018 and ongoing until compliance achieved

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A 395	Continued From page 2 The telemetry strips dated 4/7/18 at 1:23 AM identified the patient had a heart rate 71 beats per minute (bpm) with a normal sinus rhythm and had questionable changes in the Patient's rhythm at 2:55 AM and 3:54 AM. In addition, an elevation of the Patient's pulse was noted at 3:54 AM from 72 bpm to 93 bpm and at 4:09 AM, the patient's pulse was 29 bpm. Review of RN #1's nurse's note dated 4/7/18 indicated that Patient #1 was found pulseless and unresponsive at 4:05 AM and this coincided with a bradycardic event noted and alert sent by Monitor Technician #1. The cardiac arrest code sheet identified that the Patient was resuscitated from 4:12 AM on 4/7/18 to 4:30 AM, had return of spontaneous circulation and was transferred to the ICU. The CT scan dated 4/7/18 noted a left cerebral artery infarct (stroke) affecting the anterior left parietal area and ischemia of the left cerebellum. Patient #1's prognosis was poor and the Patient subsequently expired on 4/7/18 at 1:20 PM. Interview with RN #1 on 7/11/18 at 1:10 PM noted that when he began his shift on 4/6/18 at 11:00 PM, Patient #1 was restless, constantly pulling at his leads and trying to get out of the bed. RN #1 indicated that PCT #1 informed him at approximately 3:30 AM on 4/7/18 that the Patient looked sick, he assessed the Patient who "looked good" and the Patient was a little tachycardic at that time. RN #1 further identified that Monitor Tech #1 never informed him of questionable telemetry changes and the only alert he received was when the patient was bradycardic (heart rate of 38 bpm) at 4:02 AM on 4/7/18 and around the same time, the red phone rang on the unit as he was headed to the patient's room.	A 395	**A395** **Responsible Leader:** Director of Patient Care Services who oversees Inpatient Services will be ultimately responsible for the corrective action and for overall and ongoing compliance. **Plan/System Improvement:** The hospital will ensure registered nurses respond to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel. Any such changes in behavior and/or questionable cardiac rhythm changes will be reported to the appropriate covering licensed independent practitioner in a timely manner. The Director of Patient Care Services and appropriate stakeholders will review and revise, if indicated, the following policies: • Telemetry Standards of Care • Telemetry Responsibilities of the RN • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns **Implementation:** Clinical nursing staff on the inpatient medical, surgical and critical care clinical units who are responsible for assessments/reassessments and notification of changes in patient condition will review the following policies: • Cardiac Monitoring Policy / Danbury Hospital • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy	August 10, 2018 Aug 17, 2018

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A 395	Continued From page 3 Interview with Monitor Technician #1 on 7/12/18 at 9:52 AM identified that she was sending text messages back and forth to RN #1 and PCT #1 about leads being off or cable disconnected from the cardiac monitor. Monitor Technician #1 stated she spoke to RN #1 and PCT #1 about lead attachment as she was unable to see the rhythm at one point. Monitor Technician #1 stated she called PCT #1 to check leads because the patient's rhythm looked different, however, PCT #1 was on break so another PCT checked the patient and the telemetry was changed. After the telemetry was changed, Monitor Technician #1 stated she called RN #1 to check the leads, however, never received a return call despite calling a few times and a little while after that, she called the red phone on the unit when a low heart rate was identified. Monitor Technician #1 did not provide a specific timeline of the events. Interview with PCT #1 on 7/11/18 at 1:36 PM noted that Patient #1 was calm at the beginning of her shift at 11:00 PM on 4/6/18, and became restless and RN #1 was notified who told PCT #1, the patient "is ok, just a little short of breath". PCT #1 further identified that the patient became increasingly restless and the patient was assisted to the chair, however continued to be restless and short of breath. PCT #1 stated she informed RN #1 that something was wrong and she suggested that RN #1 call RT (respiratory therapist). RN #1 told PCT #1 that the patient was fine, just short of breath and did not enter the room to evaluate the patient. PCT #1 indicated that she was so worried about Patient #1, that when RN #1 did not help the Patient, She asked RN #2 to help and RN #2 indicated that this was not her patient. When RN #2 didn't respond, PCT #1 yelled out for help and	A 395	**A 395 continued** **Implementation (continued):** In addition to the review of relevant policies, clinical nursing staff on the inpatient medical, surgical and critical care clinical units who are involved in the assessment/reassessment of patients and the reporting of a change in patient condition will review the principles of the Connecticut Hospital Association's course entitled "Safety Starts with Me" with a focus on the CHAMP safety tools, particularly ARCC it Up. Should that tool not be successful, use of the "Chain of Command" Policy is indicated. **Monitoring:** A monthly audit of 30* medical records of patients who transferred to a higher level of care will be conducted for adherence to the following policies: • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy These record reviews will focus on documentation of the assessment of a change in patient condition and notification of appropriate covering licensed independent practitioner in a timely manner. This audit will be conducted until 90% compliance is achieved for four consecutive months beginning September 1, 2018. Should the audit reflect a score lower than 90%, re-education will occur with involved clinical staff.	Aug 17, 2018 Beginning Sept 1, 2018 and ongoing until compliance achieved

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A 395	Continued From page 4 RN #3 came to assist with the patient then a code was called. PCT #1 stated she did not know to notify the charge nurse when RN #1 and RN #2 failed to respond. Interview with RN #2 on 7/19/18 at 9:11 AM identified that PCT #1 did mention that her "patient was restless and that she (PCT #1) had to keep going in and out of the room. When PCT #1 expressed serious concern for Patient #1, RN #2 got up and asked RN #1 caring for the patient and another nurse on duty, RN #3 that she was informed Patient #1 wasn't doing well and both RN #1 and RN #3 said that Patient #1 was fine. RN #2 stated she went to check Patient #1, who was seated in a Geri chair and had agonal breathing. RN #2 indicated that RN #1 was unsure of the patient's code status, PCT #1 verified that Patient #1 was a full code, and RN #2 directed that a "Code" be called. Interview with MD #1 on 7/11/18 at 11:54 AM noted that he would expect to be notified if a patient became increasingly restless and would have directed that a 12 lead EKG be performed with any questionable telemetry reading. Interview with the Quality Specialist on 7/10/18 at 12:37 PM and review of the Patient's record indicated that RN #1 did not document the assessed restless behavior and did not document assessments based on PCT #1's concerns. The Quality Specialist further indicated that RN #1 should have let the provider know when the Patient had a change in condition, believed that Monitor Tech #1 had tried to inform RN #1 of the questionable telemetry changes, and a 12 lead EKG should have been performed. The Quality Specialist further identified that Monitor Tech #1	A 395	A 395 continued The results of this audit will be reported to the Danbury Hospital Quality Improvement Committee until compliance is achieved. The Danbury Hospital Quality Improvement Committee reports to the Quality Improvement Committee of the Board – who is ultimately responsible for the oversight of quality assurance and performance improvement activities for Western Connecticut Health Network. *a 100% audit will be completed should less than 30 transfers to a higher level of care have occurred within that month (approximately 60 transfers to higher level of care/month occur – an audit of 30 cases or 100% is over a 30% review)	

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A 395	Continued From page 5 stated she had called RN #1 a couple times after the telemetry box was changed for questionable telemetry changes but, RN #1 did not pick up the call. The Quality Specialist stated that her interviews with staff during the investigation identified RN #1 was aware of the patient's code status and a code was initiated immediately. The facility policy for telemetry responsibilities of the RN noted to respond to all calls from the Monitor Technician. The facility policy for scope of service 10 West identified that an interdisciplinary approach is used to provide patient care and the RN is primarily responsible to manage the patient during his/her shift. The facility RN 1 job description identified a major accountability to perform assessments in an ongoing and systematic manner.	A 395		

Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

POC accepted 8/14/18 CAD

August 10, 2018

Cheryl Davis, RN, BSN
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Dear Ms. Davis:

On behalf of Danbury Hospital, please accept the attached plan of correction in response to the July 12, 2018 State of Connecticut Department of Public Health survey. We pride our organizational participation in the Connecticut Hospital Patient Safety Collaboration as evidenced by our adoption of the principles of high reliability. In addition, we diligently review adverse events to identify issues that may lead to mandatory reporting requirements, and with complete transparency, bring them forward to the Department of Public Health on a timely basis as we did in this circumstance.

Thank you for the opportunity to review this case in greater detail. If you have any questions, please feel free to contact me via any of the contact methods noted in the signature line.

Sincerely,

Korrine Roth

Korrine Roth, MSN, CPHQ, FACHE
Administrative Director of Quality, Safety and Satisfaction
Work: (203) 739-7349
Cell: (203) 917-7974
Email: Korrine.roth@wchn.org

Danbury Hospital (0039)
Department of Public Health (DPH) July 2018 Survey Findings

Identified Violation	Plan of Correction (measures to prevent recurrence)	Corrective Measure Effective Date	Title of Person Responsible for Monitoring Plan of Correction
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).			
1. Based on medical record reviews, review of facility documentation, review of facility policies and interviews for one of ten patients who had a change in condition (Patient #1), the facility failed to ensure the RN responded to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel resulting in a delay in assessment and physician notification. The finding includes: a. Patient #1 was admitted to the hospital on 4/2/18 Patient had a small acute infarct (stroke) involving the left occipital lobe. Patient #1 was transferred to 10W (stroke unit) on 4/6/18 at 4:53 PM. Review of RN#1's assessment dated 4/6/18 at 12:42 AM identified that the patient was calm, appropriate, drowsy, was unable to determine orientation, had normal heart sounds, a regular heart rhythm, unlabored respirations, no shortness of breath, diminished breath sounds (anterior and posterior), and was on three (3) liters of oxygen. The record dated 4/7/18 identified that PCT (patient care tech) #1 documented that the Patient was transferred to the chair with two staff at 3:10 AM.	**Responsible Leader:** Director of Patient Care Services who oversees Inpatient Services will be ultimately responsible for the corrective action and for overall and ongoing compliance. **Plan/System Improvement:** The hospital will ensure registered nurses respond to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel. Any such changes in behavior and/or questionable cardiac rhythm changes will be reported to the appropriate covering licensed independent practitioner in a timely manner. The Director of Patient Care Services and appropriate stakeholders will review and revise, if indicated, the following policies: • Telemetry Standards of Care • Telemetry Responsibilities of the RN • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care	August 10, 2018	Director of Patient Care Services who oversees Inpatient Services will be ultimately responsible for the corrective action and for overall and ongoing compliance.

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Review of facility documentation identified that the Patient's heart monitor leads were off on 4/7/18 at 1:22 AM, 1:48 AM, 2:30 AM and 2:53 AM, 3:26 AM and 3:27 AM. The Patient's telemetry box was changed at 2:55 AM. The telemetry strips dated 4/7/18 at 1:23 AM identified the patient had a heart rate 71 beats per minute (bpm) with a normal sinus rhythm and had questionable changes in the Patient's rhythm at 2:55 AM and 3:54 AM. In addition, an elevation of the Patient's pulse was noted at 3:54 AM from 72 bpm to 93 bpm and at 4:09 AM, the patient's pulse was 29 bpm. Review of RN #1's nurse's note dated 4/7/18 indicated that Patient #1 was found pulseless and unresponsive at 4:05 AM and this coincided with a bradycardic event noted and alert sent by Monitor Technician #1. The cardiac arrest code sheet identified that the Patient was resuscitated from 4:12 AM on 4/7/18 to 4:30 AM, had return of spontaneous circulation and was transferred to the ICU. The CT scan dated 4/7/18 noted a left cerebral artery infarct (stroke) affecting the anterior left parietal area and ischemia of the left cerebellum. Patient #1's prognosis was poor and the Patient subsequently expired on 4/7/18 at 1:20 PM. Interview with RN #1 on 7/11/18 at 1:10 PM noted that when he began his shift on 4/6/18 at 11:00 PM, Patient #1 was restless, constantly pulling at his leads and trying to get out of the bed. RN #1 indicated that PCT #1 informed him at approximately 3:30 AM on 4/7/18 that the Patient looked sick, he assessed the Patient who "looked good" and the Patient was a little tachycardic at that time. RN #1 further identified that Monitor Tech #1 never informed him of questionable telemetry changes and the only alert he received	Plans • Chain of Command: Communication of Patient Care Concerns **Implementation:** Clinical nursing staff on the inpatient medical, surgical and critical care clinical units who are responsible for assessments/reassessments and notification of changes in patient condition will review the following policies: • Cardiac Monitoring Policy / Danbury Hospital • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy In addition to the review of relevant policies, clinical nursing staff on the inpatient medical, surgical and critical care clinical units who are involved in the assessment/reassessment of patients and the reporting of a change in patient condition will review the principles of the Connecticut Hospital Association's course entitled "Safety Starts with Me" with a focus on the CHAMP safety tools, particularly ARCC it Up. Should that tool not be successful, use of the "Chain of Command" Policy is indicated.	August 17, 2018	

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was when the patient was bradycardic (heart rate of 38 bpm) at 4:02 AM on 4/7/18 and around the same time, the red phone rang on the unit as he was headed to the patient's room. Interview with Monitor Technician #1 on 7/12/18 at 9:52 AM identified that she was sending text messages back and forth to RN #1 and PCT #1 about leads being off or cable disconnected from the cardiac monitor. Monitor Technician #1 stated she spoke to RN #1 and PCT #1 about lead attachment as she was unable to see the rhythm at one point. Monitor Technician #1 stated she called PCT #1 to check leads because the patient's rhythm looked different, however, PCT #1 was on break so another PCT checked the patient and the telemetry was changed. After the telemetry was changed, Monitor Technician #1 stated she called RN #1 to check the leads, however, never received a return call despite calling a few times and a little while after that, she called the red phone on the unit when a low heart rate was identified. Monitor Technician #1 did not provide a specific timeline of the events. Interview with PCT #1 on 7/11/18 at 1:36 PM noted that Patient #1 was calm at the beginning of her shift at 11:00 PM on 4/6/18, and became restless and RN #1 was notified who told PCT #1, the patient "is ok, just a little short of breath". PCT #1 further identified that the patient became increasingly restless and the patient was assisted to the chair, however continued to be restless and short of breath. PCT #1 stated she informed RN #1 that something was wrong and she suggested that RN #1 call RT (respiratory therapist). RN #1 told PCT #1 that the patient was fine, just short of breath and did not enter the room to evaluate the patient. PCT #1 indicated that she was so worried about Patient #1, that when RN #1 did not help the	**Monitoring:** A monthly audit of 50* reports of change in cardiac rhythm from the telemetry monitor technician to assigned registered nurse will be conducted for adherence to the following policies: • Cardiac Monitoring Policy / Danbury Hospital • Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy *a 100% audit will be completed should less than 50 reports occur within that month (approximately 140 calls/month occur from telemetry monitor technician to the assigned registered nurse – an audit of 50 cases or 100% is over a 30% review) <u>In addition:</u> A monthly audit of 30* medical records of patients who transferred to a higher level of care will be conducted for adherence to the following policies: • Chain of Command: Communication of Patient Care Concerns • Assessment / Reassessment Policy *a 100% audit will be completed should less than 30 transfers to a higher level of care have occurred within that month	Beginning Sept 1, 2018 and ongoing until compliance achieved	

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Patient, She asked RN #2 to help and RN #2 indicated that this was not her patient. When RN #2 didn't respond, PCT #1 yelled out for help and RN #3 came to assist with the patient then a code was called. PCT #1 stated she did not know to notify the charge nurse when RN #1 and RN #2 failed to respond. Interview with RN #2 on 7/19/18 at 9:11 AM identified that PCT #1 did mention that her "patient was restless and that she (PCT #1) had to keep going in and out of the room. When PCT #1 expressed serious concern for Patient #1, RN #2 got up and asked RN #1 caring for the patient and another nurse on duty, RN #3 that she was informed Patient #1 wasn't doing well and both RN #1 and RN #3 said that Patient #1 was fine. RN #2 stated she went to check Patient #1, who was seated in a Geri chair and had agonal breathing. RN #2 indicated that RN #1 was unsure of the patient's code status; PCT #1 verified that Patient #1 was a full code, and RN #2 directed that a "Code" be called. Interview with MD #1 on 7/11/18 at 11:54 AM noted that he would expect to be notified if a patient became increasingly restless and would have directed that a 12 lead EKG be performed with any questionable telemetry reading. Interview with the Quality Specialist on 7/10/18 at 12:37 PM and review of the Patient's record indicated that RN #1 did not document the assessed restless behavior and did not document assessments based on PCT #1's concerns. The Quality Specialist further indicated that RN #1 should have let the provider know when the Patient had a change in condition, believed that Monitor Tech #1 had tried to inform RN #1 of the questionable telemetry changes, and a 12 lead EKG should have been performed. The Quality	(approximately 60 transfers to higher level of care/month occur – an audit of 30 cases or 100% is over a 30% review) These audits will be conducted until 90% compliance is achieved for four consecutive months beginning September 1, 2018. Should the audit reflect a score lower than 90%, re-education will occur with involved clinical staff. The results of these audits will be reported to the Danbury Hospital Quality Improvement Committee until compliance is achieved. The Danbury Hospital Quality Improvement Committee reports to the Quality Improvement Committee of the Board – who is ultimately responsible for the oversight of quality assurance and performance improvement activities for Western Connecticut Health Network.		

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Specialist further identified that Monitor Tech #1 stated she had called RN #1 a couple times after the telemetry box was changed for questionable telemetry changes but, RN #1 did not pick up the call. The Quality Specialist stated that her interview with staff during the investigation identified RN #1 was aware of the patient's code status and a code was initiated immediately. The facility policy for telemetry responsibilities of the RN noted to respond to all calls from the Monitor Technician. The facility policy for scope of service 10 West identified that an interdisciplinary approach is used to provide patient care and the RN is primarily responsible to manage the patient during his/her shift. The facility RN 1 job description identified a major accountability to perform assessments in an ongoing and systematic manner.			